

		FOR OHF USE					

LL 1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0019489</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>ManorCare at Westmont</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/02</u> to <u>05/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>512 East Ogden Ave.</u> <u>Westmont</u> <u>60559</u> <div style="display: flex; justify-content: space-between;"> Number City Zip Code </div>		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>DuPage</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
Telephone Number: <u>(630)323-4400</u> Fax # <u>(630)323-4583</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()																									
IDPA ID Number: <u>520970446001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
Date of Initial License for Current Owners: <u>05/01/77</u>																											
Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County		<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																									
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																									
	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																									
	<input type="checkbox"/> "Sub-S" Corp.																										
	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
IRS Exemption Code _____																											
In the event there are further questions about this report, please contact: Name: <u>Gary Geise</u> Telephone Number: <u>(419)252-5731</u>																											

STATE OF ILLINOIS

Page 2

Facility Name & ID Number ManorCare at Westmont# 0019489 Report Period Beginning: 06/01/02 Ending: 05/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>155</u>	Skilled (SNF)	<u>155</u>	<u>56,575</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>155</u>	TOTALS	<u>155</u>	<u>56,575</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,948</u>	<u>4,357</u>	<u>16,942</u>	<u>25,247</u>	8
9	SNF/PED					9
10	ICF	<u>11,571</u>	<u>5,744</u>	<u>1,653</u>	<u>18,968</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,519</u>	<u>10,101</u>	<u>18,595</u>	<u>44,215</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 78.15%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/AF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 05/01/77

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 84 and days of care provided 12,922Medicare Intermediary CareFirst of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☒Tax Year: 12/31/03 Fiscal Year: 05/31/03

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

ManorCare at Westmont

0019489

Report Period Beginning:

06/01/02

Ending:

05/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	276,213	23,719	2,614	302,546	2,476	305,022		305,022		1
2	Food Purchase		168,242		168,242		168,242	(72)	168,170		2
3	Housekeeping	121,988	19,410	657	142,055		142,055		142,055		3
4	Laundry	41,985	14,114	546	56,645		56,645		56,645		4
5	Heat and Other Utilities			159,712	159,712	10,086	169,798		169,798		5
6	Maintenance	35,580	15,819	34,422	85,821		85,821		85,821		6
7	Other (specify):* Medical Waste			2,331	2,331		2,331		2,331		7
8	TOTAL General Services	475,766	241,304	200,282	917,352	12,562	929,914	(72)	929,842		8
	B. Health Care and Programs										
9	Medical Director			27,100	27,100		27,100		27,100		9
10	Nursing and Medical Records	2,563,669	195,202	33,601	2,792,472	42,952	2,835,424		2,835,424		10
10a	Therapy	564,564	2,711	86,877	654,152		654,152		654,152		10a
11	Activities	91,771	3,302	3,720	98,793		98,793		98,793		11
12	Social Services	58,034	518		58,552		58,552		58,552		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,278,038	201,733	151,298	3,631,069	42,952	3,674,021		3,674,021		16
	C. General Administration										
17	Administrative	77,078		421,760	498,838	(181,632)	317,206		317,206		17
18	Directors Fees										18
19	Professional Services			25,240	25,240	(964)	24,276	(24,276)			19
20	Dues, Fees, Subscriptions & Promotions			61,517	61,517		61,517	(29,114)	32,403		20
21	Clerical & General Office Expenses	335,569	45,490	188,769	569,828	964	570,792	(166,215)	404,577		21
22	Employee Benefits & Payroll Taxes			706,052	706,052	77,264	783,316		783,316		22
23	Inservice Training & Education			3,344	3,344		3,344		3,344		23
24	Travel and Seminar			5,129	5,129		5,129		5,129		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			153,248	153,248		153,248		153,248		26
27	Other (specify):* Personal Purchases			22	22		22	(22)			27
28	TOTAL General Administration	412,647	45,490	1,565,081	2,023,218	(104,368)	1,918,850	(219,627)	1,699,223		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,166,451	488,527	1,916,661	6,571,639	(48,854)	6,522,785	(219,699)	6,303,086		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number ManorCare at Westmont

#0019489

Report Period Beginning:

06/01/02

Ending:

05/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			265,343	265,343	48,854	314,197		314,197			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			88,653	88,653		88,653		88,653			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			46,210	46,210		46,210		46,210			35
36	Other (specify):*											36
37	TOTAL Ownership			400,206	400,206	48,854	449,060		449,060			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			3,932	3,932		3,932		3,932			38
39	Ancillary Service Centers			377,160	377,160		377,160		377,160			39
40	Barber and Beauty Shops			15,958	15,958		15,958		15,958			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			84,863	84,863		84,863		84,863			42
43	Other (specify):* IV, X-ray, Laboratory		161,859	77,473	239,332		239,332		239,332			43
44	TOTAL Special Cost Centers		161,859	559,386	721,245		721,245		721,245			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,166,451	650,386	2,876,253	7,693,090		7,693,090	(219,699)	7,473,391			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number ManorCare at Westmont

0019489

Report Period Beginning: 06/01/02

Ending: 05/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(72)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,030)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds	(3)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(384)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(22)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,446)	21		18
19	Entertainment				19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(24,276)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(148,491)	21		24
25	Fund Raising, Advertising and Promotional	(29,114)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Vending & Misc. Income	(3,861)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (219,699)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (219,699)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ManorCare at Westmont

ID# 0019489

Report Period Beginning: 06/01/02

Ending: 05/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending Income	\$ (1,809)	21	1
2	Misc. Income	(2,052)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(3,861)		49

Summary A

05/31/03

05/31/03

[illegible]

Summary B

05/31/03

05/31/03

[illegible]

Facility Name & ID Number ManorCare at Westmont# 0019489

Report Period Beginning:

06/01/02

Ending:

05/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)	Toledo, OH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3	Cost Per General Ledger	4	5	Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount		Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	\$ 421,760		HCR Manor Care, Inc.	100.00%	\$ 421,760		1
2	V	Page								2
3	V	8								3
4	V									4
5	V									5
6	V	10a	Therapy Management	36,751		Heartland Management Services	100.00%	36,751		6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total			\$ 458,511				\$ 458,511	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7

Facility Name & ID Number ManorCare at Westmont # 0019489 Report Period Beginning: 06/01/02 Ending: 05/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ManorCare at Westmont# 0019489

Report Period Beginning:

06/01/02Ending: 05/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization HCR Manor Care, Inc.Street Address 333 Noth Summit St.City / State / Zip Code Toledo, OH 43604-2617Phone Number (419) 252-5500Fax Number (419) 254-5495

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>1</u>	<u>Dietary - Direct</u>	<u>Accumulated Cost</u>	<u>2,276,617,075</u>	<u>357 Nurs. Fac</u>	<u>\$</u>	<u>\$</u>	<u>0</u>	<u>1</u>
2	<u>1</u>	<u>Dietary - Pooled</u>	<u>Accumulated Cost</u>	<u>2,686,344,447</u>	<u>357 Nurs. Fac</u>	<u>920,912</u>	<u>536,824</u>	<u>7,221,388</u>	<u>2,476</u>
3	<u>5</u>	<u>Utilities - Direct</u>	<u>Accumulated Cost</u>	<u>2,276,617,075</u>	<u>357 Nurs. Fac</u>	<u>112,862</u>		<u>7,221,388</u>	<u>358</u>
4	<u>5</u>	<u>Utilities - Pooled</u>	<u>Accumulated Cost</u>	<u>2,686,344,447</u>	<u>357 Nurs. Fac</u>	<u>3,618,915</u>		<u>7,221,388</u>	<u>9,728</u>
5	<u>10</u>	<u>Nursing - Direct</u>	<u>Accumulated Cost</u>	<u>2,276,617,075</u>	<u>357 Nurs. Fac</u>	<u>11,131,912</u>	<u>7,408,777</u>	<u>7,221,388</u>	<u>35,310</u>
6	<u>10</u>	<u>Nursing - Pooled</u>	<u>Accumulated Cost</u>	<u>2,686,344,447</u>	<u>357 Nurs. Fac</u>	<u>2,842,925</u>	<u>1,812,855</u>	<u>7,221,388</u>	<u>7,642</u>
7	<u>17</u>	<u>General & Admin - Direct</u>	<u>Accumulated Cost</u>	<u>2,276,617,075</u>	<u>357 Nurs. Fac</u>	<u>19,326,083</u>	<u>15,188,841</u>	<u>7,221,388</u>	<u>61,302</u>
8	<u>17</u>	<u>General & Admin - Pooled</u>	<u>Accumulated Cost</u>	<u>2,686,344,447</u>	<u>357 Nurs. Fac</u>	<u>66,522,981</u>	<u>38,146,902</u>	<u>7,221,388</u>	<u>178,826</u>
9	<u>22</u>	<u>Employee Benefits - Direct</u>	<u>Accumulated Cost</u>	<u>2,276,617,075</u>	<u>357 Nurs. Fac</u>	<u>2,749,439</u>		<u>7,221,388</u>	<u>8,721</u>
10	<u>22</u>	<u>Employee Benefits - Pooled</u>	<u>Accumulated Cost</u>	<u>2,686,344,447</u>	<u>357 Nurs. Fac</u>	<u>25,498,075</u>		<u>7,221,388</u>	<u>68,543</u>
11	<u>30</u>	<u>Depreciation - Direct</u>	<u>Accumulated Cost</u>	<u>2,276,617,075</u>	<u>357 Nurs. Fac</u>	<u>148,355</u>		<u>7,221,388</u>	<u>471</u>
12	<u>30</u>	<u>Depreciation - Pooled</u>	<u>Accumulated Cost</u>	<u>2,686,344,447</u>	<u>357 Nurs. Fac</u>	<u>17,998,306</u>		<u>7,221,388</u>	<u>48,383</u>
13									
14	<u>32</u>	<u>Interest</u>				<u>7,352,132</u>			<u>0</u>
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25	TOTALS					\$ 158,222,897	\$ 63,094,199		\$ 421,760

05/31/03

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.	\$	N/A	Line #
--	----	-----	--------

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)**

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ManorCare at Westmont COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0019489

CONTACT PERSON REGARDING THIS REPORT Gary Geise

TELEPHONE (419)252-5731 FAX #: (419)254-5495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>09-03-207-014</u>	<u>See attached</u>	\$ <u>86,644.00</u>	\$ <u>86,644.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>86,644.00</u>	\$ <u>86,644.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,739

B. General Construction Type: Exterior Masonry Frame Steel

Number of Stories 2

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1977	\$ 195,699	1
2					2
3	TOTALS			\$ 195,699	3

Facility Name & ID Number ManorCare at Westmont

0019489

Report Period Beginning:

06/01/02

Ending:

05/31/03

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	155			1977	\$ 1,372,073	\$ 33,086		\$ 33,086	\$	\$ 925,407	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10	Current Year Depreciation					143,456		143,456		1,189,121	9
11				1985	42,165						10
12				1986	9,808						11
13				1987	118,541						12
14				1988	118,593						13
15				1989	58,768						14
16				1990	15,910						15
17				1991	58,674						16
18				1992	84,338						17
19				1993	50,656						18
20				1994	697,677						19
21				1995	184,192						20
22				1996	118,190						21
23				1997	90,456						22
24				1998	253,224						23
25				1999	3,181						24
26	ELECTRICAL			2000	4,668						25
27	FIRE RATE CEILING			2000	890						26
28	CEDAR GATES			2000	875						27
29	FENCE			2000	3,391						28
30	PARKING LOT PAVING			2000	5,500						29
31	FIRE RATE CEILING & STEEL DOORS			2000	17,960						30
32	PAINTING-DOORS			2000	2,000						31
33	EYEWASH STATION			2000	2,545						32
34	FIRE RATE CEILINGS			2000	19,901						33
35	KEYPADS-FRONT & BACK ENTRANCES			2000	1,938						34
36	RESIDENT DOORS			2000	26,220						35
37	NURSE CALL SYSTEM			2001	44,342						36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	MISC. RENOVATIONS	2001	\$ 28,041	\$		\$	\$	\$		37
38	MISC. RENO - CURTAINS & DRAPES	2001	12,890							38
39	MISC. RENO - CARPENTRY	2001	58,208							39
40	MISC. RENO - FLOOR & WALL COVERING	2001	30,915							40
41	MISC. RENO - PLUMBING	2001	3,572							41
42	MISC. RENO - ELECTRICAL	2001	13,783							42
43	AUTOMATIC DOOR MOTOR	2001	1,889							43
44	WINDOWS	2001	15,280							44
45	FIRE DOORS	2001	7,366							45
46	DRIVEWAY	2001	8,140							46
47	VINYL WALLCOVERING	2002	1,404							47
48	WINDOW TREATMENTS	2002	907							48
49	PAINT, WVC, & CARPET	2002	8,512							49
50	INSTALL PHONE JACKS	2002	476							50
51	ELECTRIC WORK & FIXTURES	2002	2,699							51
52	CONSTRUCTION OF NEW INTERIOR WALL	2002	1,930							52
53	CONCRETE / RETAINING WALL	2002	11,871							53
54	STORAGE ROOM	2003	6,740							54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 3,621,299	\$ 176,542		\$ 176,542	\$	\$ 2,114,528		70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,178,239	\$ 88,801	\$ 88,801			\$ 957,610	71
72	Current Year Purchases	161,811						72
73	Fully Depreciated Assets							73
74				48,854	48,854			74
75	TOTALS	\$ 1,340,050	\$ 88,801	\$ 137,655	\$ 48,854		\$ 957,610	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$			\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$			\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,157,048	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 265,343	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 314,197	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 48,854	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,072,138	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 37,679 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elct. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ _____

13. /2005 \$ _____

14. /2006 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	10a	2722	hrs	\$ 78,218	68	\$ 3,107	\$ 948	2,790	\$ 82,273	1
2	Licensed Speech and Language Development Therapist	10a	1319	hrs	37,675	458	22,442	408	1,777	60,525	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	5737	hrs	172,571			1,355	5,737	173,926	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39, 2		# of prescrpts				377,160		377,160	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							
10				hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): X-ray & Laboratory	43, 3					77,473			77,473	13
14	TOTAL				\$ 288,464	526	\$ 103,022	\$ 379,871	10,304	\$ 771,357	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (76,817)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 246,496)	1,214,511		3
4	Supply Inventory (priced at)	10,179		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,809		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,153,682	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	195,699		13
14	Buildings, at Historical Cost	3,621,299		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,340,050		16
17	Accumulated Depreciation (book methods)	(3,072,138)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction In Progress	846,773		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,931,683	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,085,365	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 84,546	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	284,024		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	80,146		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	96,710		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 545,426	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 545,426	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,539,939	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,085,365	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,204,766	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,204,766	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,823,215	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,823,215	17
	B. Transfers (Itemize):		
18	Change in interdivision	(1,488,042)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1,488,042)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,539,939	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Page 19

Facility Name & ID Number ManorCare at Westmont

0019489

Report Period Beginning: 06/01/02

Ending: 05/31/03

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,547,715	1
2	Discounts and Allowances for all Levels	(2,505,176)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,042,539	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,909,042	6
7	Oxygen	7,110	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,916,152	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,809	12
13	Barber and Beauty Care	19,336	13
14	Non-Patient Meals	72	14
15	Telephone, Television and Radio	11,030	15
16	Rental of Facility Space		16
17	Sale of Drugs	384,615	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	88,437	19
20	Radiology and X-Ray	31,847	20
21	Other Medical Services	2,383	21
22	Laundry	17,320	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 556,849	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. income	2,055	28
28a	Late charges	(1,290)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 765	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,516,305	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	917,352	31
32	Health Care	3,631,069	32
33	General Administration	2,023,218	33
B. Capital Expense			
34	Ownership	400,206	34
C. Ancillary Expense			
35	Special Cost Centers	636,382	35
36	Provider Participation Fee	84,863	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,693,090	40
41	Income before Income Taxes (line 30 minus line 40)**	1,823,215	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,823,215	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **ManorCare at Westmont**# **0019489**Report Period Beginning: **06/01/02**Ending: **05/31/03**

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,074	2,202	\$ 73,452	\$ 33.36	1
2	Assistant Director of Nursing	5,111	5,426	140,041	25.81	2
3	Registered Nurses	27,272	28,949	650,620	22.47	3
4	Licensed Practical Nurses	35,734	37,931	694,488	18.31	4
5	Nurse Aides & Orderlies	85,416	90,667	979,326	10.80	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	9,809	10,494	308,614	29.41	7
8	Rehab/Therapy Aides	14,294	15,293	255,950	16.74	8
9	Activity Director	7,817	8,330	91,771	11.02	9
10	Activity Assistants					10
11	Social Service Workers	3,503	3,735	58,034	15.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,136	26,783	276,213	10.31	15
16	Dishwashers					16
17	Maintenance Workers	1,842	1,962	35,580	18.13	17
18	Housekeepers	12,880	13,732	121,988	8.88	18
19	Laundry	5,075	5,418	41,985	7.75	19
20	Administrator	2,080	2,080	77,078	37.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,577	19,925	335,569	16.84	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,026	2,161	25,742	11.91	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	258,646	275,088	\$ 4,166,451 *	\$ 15.15	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	27,100	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,279	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 33,379		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	85	\$ 4,262	10, 3	50
51	Licensed Practical Nurses	8	328	10, 3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	93	\$ 4,590		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	Description	Amount	
Donna Belocchio (Jun'02-Mar'03)	Administrator	0	\$ 68,760	Workers' Compensation Insurance	\$ 42,713	IDPH License Fee	\$ 5,021	Advertising: Employee Recruitment	21,196	
Jennifer Miller (Apr'03 -May'03)	Administrator	0	8,318	Unemployment Compensation Insurance	35,176	Health Care Worker Background Check (Indicate # of checks performed 126)	1,515	Dues & Subscriptions	200	
				FICA Taxes	298,097	Association Dues	6,950	Advertising	26,033	
				Employee Health Insurance	296,811	Public Relations	602	Less: Non-allowable Association Dues	(2,479)	
				Employee Meals		Less: Public Relations Expense	(602)	Non-allowable advertising	(26,033)	
				Illinois Municipal Retirement Fund (IMRF)*		Yellow page advertising (TOTAL (agree to Sch. V, line 20, col. 8)	\$ 32,403	
				Employee Appreiation	11,990					
				401K	19,299					
				Other Employee Benefits	(232)					
				Tuition Program	1,306					
				SMSP Match	0					
				Employee Uniforms	892					
				Home Office Allocation	77,264					
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 783,316					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 77,078	E. Schedule of Non-Cash Compensation Paid to Owners or Employees					G. Schedule of Travel and Seminar**
B. Administrative - Other										
Description			Amount	Description	Line #	Amount	Description	Amount		
Management Fees			\$ 421,760				Out-of-State Travel	\$		
							In-State Travel	5,129		
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 421,760			Includes travel expense to the Home Office in Toledo, OH for regional meetings			
(Attach a copy of any management service agreement)										
C. Professional Services							Seminar Expense			
Vendor/Payee	Type		Amount							
Foote, Meyers, Mielke, Flowers & So	Legal Fees - Collections		\$ 23,805							
Purcell & Wardrobe Chartered	Legal Fees - Collections		471							
Grantly Payne & Associates	Billing Consultant		964							
Legal fees were adjusted off on Schedule VI, Page 5, Line 22. Therefore, no legal invoices are attached.										
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				\$ 25,240	TOTAL \$					TOTAL (agree to Sch. V, line 24, col. 8) \$ 5,129

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$6950
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes \$2479
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 46,754 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 84,863
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 72
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.